IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLORADO

Civil Action No. 18-cv-01952-MSK-NYW

Andrew W. Jurgensen, Plaintiff,

v.

Doctor Gareen Hamalian, Doctor Jordan Gardner, TransUnion, Equifax, Experian, Professional Finance Company, Aargon Collection Agency, Wakefield and Associates, Denver Health, Banner Health, Defendants.

PLAINTIFF'S MOTION FOR LEAVE TO FILE UPDATED SUPPLEMENTAL CONSTITUTIONAL RECORD BRIEF AND SUPPLEMENTAL AFFIDAVIT OF MATERIAL FACT

Pursuant to F.R.C.P. 5.1, Plaintiff respectfully moves for leave to file two documents for record preservation purposes:

Exhibit B – Updated Supplemental Constitutional Record Brief

Exhibit C – Supplemental Affidavit of Material Fact Filed in Support of Judicial Misconduct Complaint and Record Preservation

This motion does not seek a ruling on the merits of any constitutional claim. Its sole purpose is to preserve a more complete and accurate record of unresolved issues—both legal and procedural—for the benefit of future judicial, legislative, or oversight review.

I. Procedural Context

The Plaintiff, a pro se litigant, initially filed a constitutional question about CRS § 27-65-105 in response to opposing motions to dismiss. Plaintiff served a Notice of Constitutional Question on the Colorado Attorney General pursuant to F.R.C.P. 5.1. Despite this, the district court never addressed—or ruled upon—the constitutional issue. The case was dismissed without any engagement of the foundational question: Does CRS § 27-65-105 require probable cause to justify police seizure?

If the statute did require probable cause, then law enforcement's conduct in detaining individuals without

it was unlawful. If it did not, then the statute itself violated the Fourth Amendment. That binary constitutional dilemma was left unresolved, foreclosing full judicial review.

Since that dismissal, the Colorado General Assembly has revised its involuntary commitment scheme by enacting CRS § 27-65-106. The revised statute continues to authorize non-judicial actors to deprive individuals of liberty—without a reasonable ground to believe criminal wrongdoing, without a judicial finding of legal incapacity, and without permission to override the right to refuse medical treatment.

This brief is submitted now because, although the statute has changed in form, the constitutional defects identified by Plaintiff remain intact, unresolved, and squarely in need of adjudication.

Plaintiff now seeks leave to file:

Exhibit B, which replaces Exhibit A with a more complete articulation of the constitutional questions; and

Exhibit C, a sworn affidavit that documents material factual misrepresentations in the judicial process and supports pending oversight investigations.

Because I served the Colorado Attorney General with notice under Rule 5.1 when I first challenged CRS § 27-65-105, the State had an opportunity to intervene—but the district court never ruled on the constitutional question, leaving the statute's scope in doubt. Only after the General Assembly repealed § 27-65-105 and enacted the unambiguous § 27-65-106 did the core defect crystallize—that Colorado's civil-commitment framework dispenses with any probable-cause requirement, in conflict with the Fourth Amendment. Until that legislative clarification, I lacked the definitive legal and factual foundation to prepare the constitutional analysis in Exhibit B and the supporting factual affidavit in Exhibit C. That post-dismissal enactment therefore constitutes good cause under Rule 5.1 for leave to file these supplemental materials to preserve the unresolved record.

II. Purpose and Relevance of Submission

These exhibits are offered not for relief, but to preserve unaddressed concerns regarding constitutional overreach, due process violations, and systemic barriers to meaningful appellate review.

Exhibit B deepens and clarifies the constitutional challenges originally presented in Exhibit A, elaborating on defects under the Fourth and Fourteenth Amendments' Due Process Clauses, while also raising parallel concerns under the Fifth Amendment where federal oversight or funding may be implicated. It introduces substantial new claims under the First Amendment's Free Exercise Clause and the Eighth Amendment's prohibition on cruel and unusual punishment.

Exhibit B supersedes Exhibit A in both content and function. It preserves the foundational question originally raised under CRS § 27-65-105—which was never adjudicated—and expands upon it in light of legislative revision. That threshold issue precluded further constitutional analysis because the statute's meaning remained ambiguous: if CRS § 27-65-105 did require probable cause, then it was enforced unlawfully; if it did not, then it was facially unconstitutional. Exhibit B presents a more robust and integrated constitutional analysis than that offered in Exhibit A. The legal analysis in Exhibits A and B was made possible by legislative clarification through the repeal of CRS § 27-65-105 and its replacement with CRS § 27-65-106, which confirmed that the State's civil commitment framework does not require probable cause as defined in Brinegar.

Citing controlling federal case law and the professional consensus on the unreliability of psychiatric dangerousness predictions, the brief demonstrates how the current statutory framework authorizes liberty deprivations without adequate judicial oversight, evidentiary standards, or procedural safeguards. It further confirms that Plaintiff does not seek immediate adjudication, but rather formal preservation of these unresolved questions for the benefit of future review.

Exhibit C documents procedural irregularities and misrepresentations in the adjudication of Case No. 18-cv-01952, and highlights how factual allegations were omitted or disregarded in the underlying ruling. It also preserves the evidentiary record for consideration in judicial conduct proceedings and civil rights review.

Together, these materials update the docket to ensure that both constitutional questions and procedural distortions are preserved in one cohesive record.

III. Relief Requested

Plaintiff respectfully requests that this Court:

Grant leave to file the attached Exhibit B and Exhibit C into the record of this case, with Exhibit B superseding the previously submitted Exhibit A; or

In the alternative, docket Exhibits B and C as attachments to this motion for permanent record retention accessible to the Court, reviewing authorities, and the public.

For the reasons stated, Plaintiff respectfully requests that the Court accept these supplemental materials for record preservation purposes, or in the alternative, docket them as permanent attachments to this motion. Doing so will allow this constitutional question to remain accessible for future institutional review.

CERTIFICATE OF SERVICE

I certify that on 09JUL2025, I mailed a true and correct copy of the foregoing Motion, and its attached Exhibit B and Exhibit C, in the U.S. Mail addressed to the Clerk of Court for inclusion in the official docket of the above-captioned case.

Because the case is closed and no parties are actively participating, service was not made on counsel of record. This motion is submitted solely for docket supplementation, record preservation, and public interest purposes and does not seek relief from any party.

I further certify that on 09JUL2025, I placed true and correct copies of this Motion and attached Exhibits B and C in the U.S. Mail, postage prepaid, addressed to:

Colorado Attorney General's Office

Ralph L. Carr Judicial Building

1300 Broadway, 10th Floor

Denver, CO 80203

Main Office (Denver): United States Attorney's Office

Attn: Criminal Division – Civil Rights Enforcement

1801 California Street, Suite 1600

Denver, CO 80202

Respectfully submitted,

Andrew Jurgensen Pro Se Litigant noonepokedmyeyeout@gmail.com 09JUL2025

—— EXHIBIT B —— Updated Supplemental Constitutional Record Brief

Updated Supplemental Constitutional Record Brief: Constitutional and Evidentiary Objections to Civil Mental Health Seizures Based on "Dangerousness"

Submitted by Andrew Jurgensen, Plaintiff

I. Introduction and Constitutional Framework

This Updated Supplemental Constitutional Record Brief is submitted pursuant to Federal Rule of Civil Procedure 5.1 to preserve unresolved constitutional challenges to Colorado's civil psychiatric detention framework, now codified at CRS § 27-65-106. Although the Plaintiff previously raised a constitutional question about its predecessor (§ 27-65-105), that issue was never adjudicated. Critically, the threshold constitutional question—whether the statute required probable cause to justify police seizure—was left unanswered. If the old law did require probable cause, then law enforcement acted unlawfully in detaining individuals without it. If it did not, then the statute itself violated the Fourth Amendment. That foundational ambiguity foreclosed full constitutional review.

Following the statute's revision and re-enactment, core constitutional defects persist. CRS § 27-65-106 empowers non-judicial actors—clinicians, deputies, and hospital staff—to detain and forcibly medicate legally competent individuals absent any finding of criminal wrongdoing, legal incapacity, or voluntary consent. It supplants probable cause with clinical conjecture; replaces judicial oversight with bureaucratic discretion; and allows liberty to be suspended based not on adjudicated fact, but on psychiatric speculation. These are not procedural deficiencies—they are constitutional violations.

This brief assembles controlling legal authority, empirical data, and comparative standards to demonstrate that CRS § 27-65-106 fails to satisfy fundamental requirements of state and federal constitutional law. It does not seek immediate judicial relief. Rather, it preserves a structured legal record for those bodies—courts, legislatures, and institutional review authorities—that must ultimately confront the legality and legitimacy of this regime.

At its core, this case poses a question of constitutional first principles: May the state, through civil process, deprive a person of liberty without probable cause, without adversarial process, and without judicial review—based solely on speculative psychiatric assessments? This brief answers unequivocally: it may not. Civil detention is not a constitutional escape hatch. The state cannot do by medical opinion what it is forbidden to do by law. When liberty is at stake, only tested evidence, meaningful process, and neutral oversight suffice. CRS § 27-65-106 offers none of these—and for that reason, it demands searching

constitutional review.

II. Foundational Constitutional Defects

CRS § 27-65-106 authorizes the involuntary psychiatric seizure and confinement of individuals based on a non-judicial, undefined "dangerousness" standard. This statutory framework violates the United States Constitution in multiple, interlocking ways: it is void for vagueness under the Due Process Clause; it represents an unconstitutional delegation of power to non-judicial actors; and it authorizes seizures without probable cause, bypassing the Fourth Amendment's protections. These defects are not theoretical—they are structural, substantive, and facially unconstitutional.

To the extent that involuntary psychiatric procedures are federally funded through programs such as Medicaid or governed by federal civil rights obligations, the procedural protections of the Fifth Amendment apply in parallel to those arising under the Fourteenth.

A. Vagueness of the "Dangerousness" Standard

The Due Process Clause prohibits statutes that fail to provide clear, objective standards for enforcement. A law is void for vagueness when it "fails to give ordinary people fair notice of the conduct it punishes" or "invites arbitrary and discriminatory enforcement." Johnson v. United States, 576 U.S. 591, 595–96 (2015); Connally v. Georgia, 269 U.S. 385, 391–92 (1926) ("a statute must be sufficiently explicit to inform those who are subject to it what conduct on their part will render them liable to its penalties").

CRS § 27-65-106 fails this test in full. It provides no definition of "dangerousness" and articulates:

No time frame (e.g., how imminent the perceived danger must be);

No behavioral predicate (e.g., what conduct qualifies as threatening);

No evidentiary threshold (e.g., whether independent corroboration is required).

This indeterminacy:

Invites capricious detentions based on implicit bias, stigma, or administrative discretion; and

Vests unchecked authority in non-judicial actors to determine when the State may seize, confine, and forcibly medicate a citizen—without judicial oversight, evidentiary standards, or procedural safeguards during the initial 13-day confinement period, and in many cases, without any such safeguards ever being triggered if no formal certification is pursued.

No constitutional system can permit liberty to be stripped on the basis of such an elastic and undefined standard. The statute's ambiguity renders the threshold for confinement unknowable, unchallengeable, and fundamentally unlawful.

B. Unconstitutional Delegation and Unreviewable Forced Medication

CRS § 27-65-106 violates core separation-of-powers principles by transferring the power to define legal standards (legislative authority) and the power to deprive individuals of liberty or bodily autonomy (judicial authority) to non-judicial actors—including psychiatrists, hospital personnel, and law enforcement officers, many of whom are not government employees. These actors operate under a statutory framework that provides no meaningful constraints or mechanisms of review.

Legislative Overreach: Undefined Standards

The statute delegates to executive and private actors the task of determining when a citizen is "dangerous," yet supplies no statutory definition, limiting criteria, or procedural safeguards to guide that determination. This lack of an "intelligible principle" violates the nondelegation doctrine. [See A.L.A. Schechter Poultry Corp. v. United States, 295 U.S. 495, 537–38 (1935).]

In effect, the legislature has outsourced legal rulemaking to clinicians and police, enabling ad hoc and unaccountable interpretations of "dangerousness."

Judicial Bypass and Emergency Drugging Without Oversight

Beyond legislative overreach, CRS § 27-65-106 empowers non-judicial personnel to initiate confinement and administer involuntary medication based solely on an unverified claim of "emergency"—without a prior hearing, evidentiary testing, or judicial oversight. Specifically, the statute:

Authorizes detention and forced drugging without sworn testimony or adversarial process;

Bypasses pre-deprivation hearings before a neutral magistrate;

Requires no factual findings or written justification; and

Permits emergency medication that may never be reviewed by a court if the individual is released before a certification hearing.

This procedural void is especially alarming: individuals can be forcibly medicated—sometimes repeatedly—without ever receiving a hearing or opportunity to challenge the claimed emergency. Even People v. Medina, 705 P.2d 961 (Colo. 1985), which requires a full adversarial hearing and clear and

convincing evidence before non-emergency medication may be administered, provides no protection when facilities invoke the "emergency" exception and discharge patients before formal judicial review is triggered.

Structural Breakdown CRS § 27-65-106 empowers non-judicial actors—including police, hospital staff, and private clinicians—to exercise unchecked legislative and adjudicatory authority from the moment of initial detention. For up to 72 hours, these actors may confine and forcibly medicate individuals based solely on their own unreviewed judgment that someone poses a risk—a standard the statute fails to define with any objective criteria.

If the facility files for certification, the statute permits continued confinement for up to 14 days from the time of initial detention before a hearing is required. During this time, procedural safeguards remain minimal: there is no automatic judicial review of the initial hold, no adversarial process to contest emergency medication, and no requirement for sworn testimony or findings of fact.

The result is a statutory regime that delegates profound state powers—detention and chemical restraint—to non-judicial personnel, including private actors, under vague standards and with vanishingly little oversight. CRS § 27-65-106 does not merely pose risks in application; it institutionalizes a due process vacuum.

C. Seizures Without Probable Cause

The Fourth Amendment prohibits the government from depriving individuals of liberty without probable cause—and Brinegar v. United States, 338 U.S. 160, 175–76 (1949) held that, "The substance of all the definitions of probable cause is a reasonable ground for belief of guilt." The Colorado civil commitment statute, CRS § 27-65-106, authorizes involuntary psychiatric confinement in the complete absence of such cause. It permits the seizure of individuals based solely on clinicians' predictive judgments of "dangerousness," untethered to any concrete evidence, judicial oversight, or adversarial review.

Critically, these are not momentary detentions—they are often 72-hour or 13-day holds involving forced hospitalization, coerced medical treatment, and the loss of basic rights. The notion that this is somehow exempt from constitutional scrutiny because it is labeled "civil" is flatly contradicted by Camara v. Municipal Court, 387 U.S. 523, 530 (1967), where the Supreme Court made clear that civil intrusions are not immune from Fourth Amendment oversight. "The basic purpose of the Fourth Amendment," the Court stated, "is to safeguard the privacy and security of individuals against arbitrary invasions by governmental officials," and this safeguard applies equally to both civil and criminal contexts. Id. at 528. If even a routine civil housing inspection requires constitutional justification via a warrant which may only issue

upon probable cause, then a far more invasive act—psychiatric seizure—must require at least as much.

While Camara acknowledged that administrative inspections might rely on general enforcement patterns, it did not authorize bodily seizures without individualized evidence. And even there, it still required a warrant. Here, the government performs a far more invasive act—a psychiatric confinement—without a warrant, without judicial review, and without a reasonable belief of lawbreaking. The Fourth Amendment does not shrink when the government relabels its actions as 'civil.' It demands a warrant, and it demands probable cause—as Brinegar defines it—for any deprivation of liberty.

Yet CRS § 27-65-106 abandons these constitutional safeguards entirely. It requires no warrant, no evidentiary foundation established in a court of law, and no review by a neutral magistrate. Instead, it authorizes the involuntary confinement of individuals based solely on speculative, forward-looking psychiatric assessments. In doing so, it vests unilateral arrest power in private clinicians acting outside judicial supervision—an authority the Supreme Court explicitly forbids in Camara and Ybarra v. Illinois, 444 U.S. 85 (1979).

Even more concerning, the statutory regime functionally incentivizes unlawful detention by threatening mental health professionals with civil liability if they fail to predict and prevent future violence. Under Colorado's duty-to-warn laws, providers face liability for "negligent failure to initiate involuntary seventy-two-hour treatment and evaluation after a personal patient evaluation determining that the patient appears to have a mental illness, and as a result of that illness would be an imminent danger to others." This statutory framework coerces clinicians into erring on the side of incarceration, despite psychiatry's long-standing admission that predictions of dangerousness are scientifically unreliable. As the American Psychiatric Association emphasized in its Brief Amicus Curiae of the American Psychiatric Association, Tarasoff v. Regents, No. S.F. 23042 (Cal. Sup. Ct. 1976)

"Neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.'" "Study after study has shown that this fond hope of the capability accurately to predict violence in advance is simply not fulfilled." "This newly established duty to warn imposes an impossible burden upon the practice of psychotherapy. It requires the psychotherapist to perform a function which study has shown he is ill-equipped to undertake; namely, the prediction of his patient's potential dangerousness."

Worse still, this regime does not merely permit—but actively incentivizes—constitutional violations: a psychiatrist who honors their patient's Fourth Amendment rights by declining to detain without probable cause may be held civilly liable if violence later occurs. In effect, Colorado law punishes clinicians for refusing to execute seizures the Constitution forbids. This is not a regulatory oversight—it is a deliberate inversion of constitutional priorities, placing liability on those who comply with the Bill of Rights and

legal immunity on those who override it through speculative detention.

A predictive diagnosis is not a judicial ruling. A clinician's impression is not probable cause. And labeling a seizure "civil" does not exempt it from constitutional scrutiny. The state may not wield psychiatry as a workaround to authorize what the Constitution forbids. CRS § 27-65-106 permits detentions wholly untethered from any legitimate Fourth Amendment foundation—and reinforces them through the threat of civil liability—thereby sanctioning seizures that are unconstitutional from inception. But the Constitution demands more than professional intuition: it requires a specific, individualized, evidence-based reason to believe that the person to be seized has committed a crime. When a statute conflicts with that command, the rule of law remains unwavering:

"Certainly all those who have framed written constitutions contemplate them as forming the fundamental and paramount law of the nation... It is emphatically the province and duty of the judicial department to say what the law is... So if a law be in opposition to the Constitution... the Constitution, and not such ordinary act, must govern the case to which they both apply."

"A law repugnant to the Constitution is void." —Marbury v. Madison, 5 U.S. (1 Cranch) 137, 177 (1803)

D. Contextualizing Civil Seizures as Criminal Acts

D.1 Criminal Equivalence of Psychiatric Seizures

CRS § 27-65-106 doesn't merely stretch constitutional boundaries—it authorizes conduct that, once the medical veneer is peeled away, matches textbook crimes. Seizing someone without a warrant, without probable cause, and without any judicial finding of incapacity used to satisfy the elements of false imprisonment (C.R.S. § 18-3-303), second-degree kidnapping (C.R.S. § 18-3-302), and—if the person dies—first-degree murder (C.R.S. § 18-3-102). Until recent changes to these laws went into effect, civil commitment seizures would have been prosecutable under these statutes.

D.2 Legislative Immunization

As courts and advocates exposed these parallels, Colorado's legislature quietly rewrote its criminal code to sweep involuntary psychiatric holds outside the reach of ordinary prosecution. The statutes defining false imprisonment, kidnapping, and homicide were amended to exclude conduct performed under the civil-commitment scheme. What once met every element of a felony can now be carried out with near-total immunity.

Elijah McClain's death drives the point home. McClain was initially seized—his wrist grabbed—without any reasonable suspicion of wrongdoing and despite posing no threat. He was then moved involuntarily

"to the grass," sedated without consent, and died soon after. Yet instead of pressing charges under these statutes, the State maintained its commitment procedures, declined to prosecute his killers for second degree kidnapping and first degree murder, and adjusted the felony definitions so that similar future conduct could never be challenged as a crime. This was not reform—it was institutional self-preservation.

D.3 Constitutional Evasion and Equal Protection

CRS § 27-65-106 survives only because Colorado gutted three bedrock felonies—false imprisonment (C.R.S. § 18-3-303), second-degree kidnapping (C.R.S. § 18-3-302), and first-degree murder (C.R.S. § 18-3-102)—and reclassified any doctor-ordered "detention" as a mere misdemeanor. By imposing technical hurdles (force plus 12-hour confinement) and carving out a medical-procedures defense, the legislature stripped these seizures of their felony character and eliminated the state-law predicates for any federal RICO claim.

Even more baffling is the new "risk of harm" test in the kidnapping statute—did moving a person into a hospital actually increase their danger? What would the counterfactual world look like if they'd never been moved? If a patient dies during involuntary commitment, did the treatment heighten their risk? If a detained patient ends their own life under the crushing weight of medical bills, does that count? Will prosecutors ever pursue these scenarios—or has the legislature rendered criminal safeguards entirely hollow?

These carve-outs also eviscerate equal protection. Every Coloradan enjoys criminal-law protection against abduction and unlawful restraint—except the mentally ill. If I drag someone into my car, take them to a locked room, and keep them there without lawful authority for days, I will be correctly branded a felon by the criminal system; a psychiatric patient subjected to identical treatment is labeled "care" and lies beyond the protection of criminal law enforcement. In effect, the mentally ill become second-class citizens, denied protection from the very laws that were supposed to be designed to protect them.

This is legalized exceptionalism: a fiction that psychiatric detention occupies a realm outside criminal accountability, sanitized by therapeutic rhetoric. Benevolent intent does not erase inflicted harm, and legislative tinkering cannot expunge culpability. Peel back the clinical veneer, and you see the same conduct—false imprisonment, kidnapping, even death—that could once have carried felony penalties, if prosecutors had ever wanted to press charges, recast as mere misdemeanors, excused by statute and stripped of any path to RICO or meaningful prosecution.

The Constitution does not bow to administrative convenience or shifting policy whims. It demands the equal application of its safeguards and an honest accounting of wrongdoing. This isn't a critique of the Constitution—it's a call-out of lawmakers who rewrote Colorado's criminal statutes to shield state-

sanctioned kidnappings and deny the mentally ill the equal-protection guarantees everyone else enjoys.

E. Failure of the Mathews v. Eldridge Due Process Balancing Test

The constitutional floor for civil commitment procedures is not a mystery—it has been defined repeatedly by the Supreme Court. In Addington v. Texas, 441 U.S. 418 (1979), the Court held that involuntary psychiatric confinement demands "clear and convincing" evidence and must be predicated on rigorous procedural safeguards, given the "massive curtailment of liberty" it imposes. Lassiter v. Dep't of Soc. Servs., 452 U.S. 18 (1981), further confirmed that when physical liberty is at risk in civil proceedings, the appointment of counsel may be constitutionally required—especially where the individual cannot effectively advocate for themselves.

Under Mathews v. Eldridge, 424 U.S. 319 (1976), courts evaluate procedural sufficiency by balancing three factors:

The private interest affected;

The risk of erroneous deprivation under existing procedures; and

The government's interest, including the administrative burden of additional safeguards.

CRS § 27-65-106 fails all three. It threatens the most fundamental liberty—bodily autonomy—based on speculative and unreviewable assessments; it offers no adversarial testing to guard against error; and it imposes no procedural burden beyond what criminal and juvenile courts already manage. A statute that bypasses each of these constitutional safeguards is not a narrow exception—it is a direct violation of due process.

Private Interest: At stake is personal liberty and bodily integrity—"Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action... It is clear that commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." Foucha v. Louisiana, 504 U.S. 71, 80 (1992). The statute permits confinement, forced psychiatric evaluation, and involuntary drug administration without judicial authorization, profoundly impacting the individual's autonomy, legal status, and mental and physical health.

In Plaintiff's case, this harm extended beyond confinement: the financial cost of hospitalization was reported as debt on Plaintiff's consumer credit file. If such charges are to be treated as contractual obligations, they are unenforceable under Article I, Section 10 of the United States Constitution absent an

express agreement between the parties. No such agreement existed.

The result was reputational and economic damage. When Plaintiff attempted to rent an apartment and offered to prepay the full term of a one-year lease, the offer was rejected due to a low credit score—an outcome stemming directly from this contested medical debt. At that point, Plaintiff recognized that clearing the credit record was essential to rebuilding his life. Yet despite repeated efforts, Plaintiff was unable to do so. The listed debt arose without a judgment from a court of law and without an agreement expressly authorizing the amount owed, thereby violating provisions of the Fair Debt Collection Practices Act (F.D.C.P.A.) related to unfair and deceptive practices under 15 U.S.C. § 1692f.

Worse still, Plaintiff reasonably believed that securing employment would expose him to legal and moral complicity. Because income taxes fund Medicare and Medicaid—programs which, in practice, are frequently used to subsidize involuntary psychiatric interventions that violate Fourth Amendment rights—Plaintiff feared that gainful employment would render him complicit in what he understood to be ongoing criminal conduct under both 18 U.S.C. § 241 (Conspiracy Against Rights) and C.R.S. § 18-3-303 (False Imprisonment). This belief was not speculative; it was grounded in personal experience and statutory analysis. To knowingly fund or enable programs that facilitate unconstitutional seizures would, in Plaintiff's view, constitute participation in the deprivation of rights under color of law. In this respect, creating and submitting this brief was not merely a legal act—it was a moral and constitutional necessity. In the absence of accessible redress or institutional accountability, abstaining from employment and documenting this harm became the only means by which Plaintiff could avoid further complicity.

Thus, the private interest here includes not only liberty and bodily autonomy, but also reputational harm, economic exclusion, and the coerced moral paralysis imposed by a system that weaponizes public funds against constitutional protections. The deprivation is not abstract—it is complete.

Risk of Erroneous Deprivation: The Constitutional Collapse of Psychiatric Dangerousness Prediction

The statute is architected around speculative, non-adversarial clinical determinations of "dangerousness"—judgments that both courts and the psychiatric profession have acknowledged are routinely prone to error. In Barefoot v. Estelle, 463 U.S. 880, 920 (1983), the Supreme Court recognized that psychiatric predictions of future violence are "not always wrong, but… often inaccurate." The American Psychiatric Association has gone further, describing the task of forecasting dangerousness as "an impossible burden" that psychiatrists are "ill-equipped to undertake." Brief for Am. Psychiatric Ass'n as Amicus Curiae, Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334 (1976).

In that brief, the APA cited a pivotal empirical study, noting: "A question that might be raised at this point is whether our data can address the issue of the abilities of psychiatrists to make these predictions as to dangerousness. This question rests on the assumption that there are bases in psychiatric training,

perspective, and skills that give psychiatrists a special ability to make such predictions. In the 256 cases studied here we have examined how the psychiatric prediction of dangerousness is actually being done. There seemed to be little in the way of special abilities evident in these cases. It is our opinion that our data, together with a lack of documentation in the literature for psychiatric abilities to accurately predict dangerousness, seriously question any assumption that there is such a special psychiatric expertise. (Steadman, Some Evidence on the Indequacy of the Concept and Determination Dangerousness in Law and Psychology, 1 Journal of Psychiatry and Law 409, 421—2 (1973); emphasis added.)"

The Constitution requires more than professional judgment when liberty is at stake—it demands evidentiary rigor. In Addington v. Texas, 441 U.S. 418 (1979), the Supreme Court held that the state may not civilly commit individuals absent "clear and convincing evidence" that they suffer from mental illness and pose a danger to themselves or others. But that burden—when applied to psychiatric prediction—is not merely high; it is, by the profession's own admission, functionally impossible to meet with reliability.

As the American Psychiatric Association acknowledged in its amicus brief in Tarasoff v. Regents of the University of California, 17 Cal. 3d 425 (1976):

"This newly established duty to warn imposes an impossible burden upon the practice of psychotherapy. It requires the psychotherapist to perform a function which study has shown he is ill-equipped to undertake; namely, the prediction of his patient's potential dangerousness."

This was not rhetorical flourish—it was rooted in empirical research. Numerous studies, including Steadman (1973), have demonstrated that clinicians' predictive accuracy regarding future violence hovers barely above chance. This unreliability has been judicially acknowledged (see Barefoot), reinforcing that the danger is not hypothetical—it is known.

Thus, to require clear and convincing evidence of future dangerousness is to demand epistemological certainty from a field that itself concedes it lacks the tools to deliver it. That is not a safeguard—it is a false promise.

CRS § 27-65-106 doesn't merely entrust psychiatrists with discretion—it deputizes them to make legal determinations they are, by their own account, "ill-equipped" to perform. When these determinations lead directly to involuntary confinement, forced medication, and the stripping of fundamental rights, the constitutional stakes multiply. A process that begins with what psychiatry calls "an impossible burden" cannot end in lawful deprivation of liberty.

The result is a system where the constitutional standard is both facially unmet and professionally disclaimed. That is not due process. It is its abdication.

Despite this well-documented unreliability, CRS § 27-65-106 compels clinicians to initiate confinement

and treatment based precisely on these forecasts—absent independent review, evidentiary testing, or adversarial challenge. In this way, the statute institutionalizes one of the most error-prone judgment calls in clinical practice as a legally sufficient basis for seizure.

While Camara v. Municipal Court, 387 U.S. 523 (1967), acknowledged that civil inspections might be justified through general enforcement patterns, it nonetheless required a warrant and judicial oversight. The Court made plain that the Fourth Amendment's protections against arbitrary government intrusion apply equally in civil and criminal contexts. As it stated: "The basic purpose of the Fourth Amendment… is to safeguard the privacy and security of individuals against arbitrary invasions by governmental officials." Id. at 528.

This principle is reinforced by Brinegar v. United States, 338 U.S. 160, 175–76 (1949), where the Court defined "the substance of all the definitions of probable cause" as "a reasonable ground for belief of guilt" which emphasized that this standard is not context-dependent. Probable cause, as constitutionally defined, is a floor, not a variable.

If even a routine civil housing inspection requires constitutional justification via a warrant supported by probable cause, then a far more invasive act—psychiatric seizure—must require at least as much.

CRS § 27-65-106 abandons these protections entirely. It compels clinicians to initiate confinement and treatment based solely on speculative psychiatric forecasts—without independent review, adversarial testing, judicial authorization, evidentiary grounding, or any finding of criminal wrongdoing. The result is a statutory regime that authorizes liberty deprivations not through law, but through unchecked medical speculation—where the cost is not regulatory inconvenience, but life-altering confinement and coercive medication.

Government's Interest and Administrative Burden: While the State claims an interest in public safety and emergency treatment, that interest can be vindicated through modest procedural enhancements: prompt probable-cause hearings, judicial oversight for forced treatment, appointed counsel, and access to real-time challenge mechanisms. These protections are standard in criminal, medical, and juvenile proceedings and do not impose a heavy administrative burden compared to the grave harms resulting from erroneous confinement and forced medication.

Yet under CRS § 27-65-106, a disturbing loophole has emerged—one that allows the state to extinguish liberty and bodily autonomy without ever triggering constitutional review. Here's how the scheme operates in practice:

A clinician initiates a 72-hour hold by affidavit, alleging "imminent danger."

During that hold, the individual may be forcibly medicated under emergency protocols—without court

orders, judicial findings of incompetence, or risk–benefit analysis.

Before the 72-hour period ends, the facility seeks an automatic extension of confinement to 13 days by alleging continued danger—again without notice, counsel, or hearing.

Just before the statutory hearing deadline arrives on day 13, the individual may be discharged, now docile due to forced medication. No hearing is held, no record is created, and no forum exists for post hoc challenge. The legal case simply vanishes.

This process creates a procedural black hole: no warrant, no hearing, no finding of incapacity, and no judicial record. Once the patient is released, appellate review becomes impossible. The statute authorizes unreviewed and irreversible medical coercion—administered to free and competent adults—in direct contravention of Supreme Court precedent. In Washington v. Harper, 494 U.S. 210 (1990), the Court held that even convicted prisoners cannot be forcibly medicated absent procedural safeguards and findings of dangerousness. And in Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990), it confirmed that competent individuals have a constitutionally protected right to refuse medical treatment. Colorado law upends both principles: under CRS § 27-65-106, presumed-competent civil detainees may be forcibly injected with antipsychotics—without a judicial finding of incapacity, and without ever having the chance to contest the intervention. If Cruzan requires heightened safeguards before withdrawing life-sustaining care, then overriding conscious objection through nonjudicial fiat falls far below the constitutional minimum.

This is not due process—it is its systematic negation. CRS § 27-65-106 fails Mathews not merely in theory, but in practice. It enables pre-hearing abuse and post-discharge impunity, rendering the procedural protections of the Fourteenth Amendment functionally meaningless. Such a regime is not constitutionally deficient at the margins—it is structurally incompatible with due process and must be struck down.

Addington established the evidentiary barrier. Mathews created the procedural map. CRS § 27-65-106 bypasses both—conferring the power to confine not on neutral judges armed with clear and convincing evidence, but on clinicians armed with no findings at all. The result is a legal regime that satisfies neither burden nor process—and violates both.

These constitutional failures are not abstract—they are lived. What follows in Section III is one such account: a death witnessed under the shadow of a statute now preserved in the record, but—so far as Plaintiff is aware—never examined in court.

F. Violations of the Right to Bodily Privacy and Retaliation for Asserting Civil Rights

In multiple involuntary confinement settings—including Banner Health and the facility where Plaintiff was held prior to being transported to Denver Health without warning or consent—Plaintiff was subjected to continuous visual surveillance by cameras capturing approximately 30 images per second. These cameras were positioned in rooms where Plaintiff was held under force or threat of force, despite the absence of any criminal investigation, judicial removal of rights, or voluntary consent to being recorded.

This practice directly violated the facilities' own posted Patient Rights Statements, which affirm that individuals maintain the right to refuse medical treatment and the right not to be photographed except for identification purposes. While confined at Banner Health, Plaintiff exercised these rights by physically redirecting a surveillance camera away from his person. In response, staff entered the room, forcibly repositioned the camera, and dismissed Plaintiff's objections. When Plaintiff again asserted the violation—this time citing the rights document provided by the facility—staff repeated the same actions, without acknowledgment or remedial action.

After multiple denials of his request to cease unlawful surveillance, Plaintiff ultimately removed the camera to halt the unauthorized recording. Rather than investigating or remedying this civil rights violation, hospital staff responded by transferring Plaintiff to another facility and reporting the incident to law enforcement. No attempt was made to contact Plaintiff for a statement. Instead, a detective—identified in records as "Denise"—unilaterally issued an arrest warrant for destroying the hospital's surveilance equipment.

As a result, Plaintiff was compelled to navigate additional criminal legal proceedings that arose not from misconduct, but from an effort to exercise a civil right the hospital explicitly claimed he possessed and then actively denied him in practice.

This episode further exemplifies the institutional pattern identified throughout this brief: that facilities do not merely disregard civil liberties—they punish those who try to invoke them. By criminalizing the assertion of rights, these institutions obliterate the line between care and coercion. Due process becomes a formality, and silence is incentivized through retaliation.

The Constitution's protections do not dissolve upon psychiatric admission. Surveillance without legal authority, followed by prosecution for resisting it, is not treatment—it is state-enabled reprisal. The judiciary must not ignore what such systems so plainly reveal: when civil rights are neither acknowledged nor enforceable, they cease to exist in any meaningful sense.

G. Denial of Adversarial Review During Emergency Detention

Even beyond its structural due process deficiencies, CRS § 27-65-106 fails in its most basic procedural

obligations: it denies individuals access to any adversarial forum during the most critical phase of confinement. For up to thirteen days, legally competent adults may be seized, forcibly medicated, and held under conditions that would trigger full constitutional protections in any other context—without ever seeing a judge.

The Supreme Court has made clear that even temporary deprivations of liberty require meaningful procedural safeguards. In Goss v. Lopez, 419 U.S. 565 (1975), the Court held that public school students facing a brief suspension are entitled to notice and a hearing. When the liberty interest is as profound as bodily detention and compelled psychiatric drugging, the need for adversarial process is exponentially greater. As Addington v. Texas, 441 U.S. 418 (1979), emphasized, involuntary psychiatric commitment demands at minimum "clear and convincing" evidence and an opportunity to contest state allegations.

CRS § 27-65-106 institutionalizes the absence of both.

No counsel is appointed at the time of initial seizure. No hearing occurs during the first 72-hour emergency hold. If the facility seeks to extend confinement, the process remains one-sided: the individual often receives no notice, no representation, and no access to contest the extended detention. Critically, in many cases, the patient is discharged just before the 14-day statutory hearing deadline—now medicated into compliance—without a hearing ever taking place.

Even when counsel is technically appointed during the extended hold period (between day 3 and day 13), the systemic expectation that no hearing will ever occur corrodes the quality and readiness of legal advocacy. Attorneys assigned to represent mental health clients in these cases are frequently conditioned to assume that day 14 will never arrive. As a result, they may triage their casework accordingly, preparing only cursory defenses or delaying full investigation because the prevailing pattern is that clients will be released—without judicial review—before any adversarial process can begin. This is not a critique of individual lawyers, but of a system whose procedural design trains its defenders not to expect justice, and whose incentives discourage robust advocacy in cases where the defense may never be heard.

Even when legal representation is technically assigned, the statute's structure actively undermines its function—rendering counsel inert at precisely the moment it is most needed.

The Supreme Court has long recognized that the right to counsel is not a luxury—it is a constitutional necessity where liberty is at stake. In Gideon v. Wainwright, 372 U.S. 335, 344 (1963), the Court held that counsel is essential to a fair trial and a fundamental safeguard of due process. In Lassiter v. Dep't of Soc. Servs., 452 U.S. 18, 25 (1981), it acknowledged that even in civil proceedings, the right to appointed counsel may be required when physical liberty is threatened. And in Murray v. Giarratano, 492 U.S. 1, 10 (1989), the Court emphasized that the absence of a right to counsel in postconviction proceedings was constitutionally permissible only because the defendant had already received full adversarial process. CRS

§ 27-65-106 offers no such adversarial process—not at the time of seizure, not at the time of confinement, not at the time the hold is extended, and often not even at the time of discharge. It authorizes confinement and coercive treatment without trial, without hearing, and without representation. That is not due process, it is denial of due process.

Meanwhile, forced medication is carried out under emergency declarations that are never subjected to judicial review. There is no requirement that a judge authorize the emergency intervention or validate its necessity after the fact. No evidentiary hearing, no post hoc justification, no neutral finding ever occurs. The emergency remains untested, the medication unreviewed, the individual unrepresented.

But however the state frames it—"emergency treatment," "civil hold," or "temporary evaluation"—the result is a government-imposed deprivation of liberty. And as the Supreme Court confirmed in Camara v. Municipal Court, 387 U.S. 523, 530 (1967), the Fourth Amendment's protection against unreasonable seizures applies in both civil and criminal contexts. The Constitution does not permit liberty to be taken by administrative label.

As Brinegar v. United States, 338 U.S. 160, 175 (1949), makes clear, "[t]he substance of all the definitions of probable cause is a reasonable ground for belief of guilt." Colorado's civil framework allows detention based not on probable cause, but on predictive clinical assessments untethered to any suspicion of criminal wrongdoing. In doing so, it authorizes precisely the kind of suspicionless seizure that the Fourth Amendment forbids.

In practice, this leaves competent adults vulnerable to coercive drugging based solely on staff discretion. The author of this brief has observed individuals injected with Zyprexa not for violence, but for disfavored behavior: a man named Brian was injected for raising his voice; a woman named Catherine was injected for momentary partial public nudity. At Clearview Behavioral Health, a physician ordered the author of this brief to be forcibly injected with Zyprexa solely for declining medication over a period of three days—without any judicial finding of incapacity, without any evidence of emergent threat, and without ever being afforded an opportunity to contest the intervention. These are not examples of clinical emergency. They are the result of unchecked authority and the systemic evasion of process.

This sequence ensures that no judicial record is created, no findings are made, and no opportunity arises to challenge the legality of the confinement or the medication. The Supreme Court has affirmed that even incarcerated individuals have a right to access courts to challenge the conditions of confinement. Bounds v. Smith, 430 U.S. 817 (1977). CRS § 27-65-106 provides no such access during the hold—no court, no record, no opportunity to object. The result is constitutional silence imposed by statutory design. Upon discharge, any chance for meaningful appellate review disappears—extinguished before it ever emerged. This is not a loophole; it is a designed procedural vacuum that precludes constitutional accountability.

Even convicted prisoners retain a right to refuse medical treatment unless and until a neutral decisionmaker finds incapacity or dangerousness. Washington v. Harper, 494 U.S. 210, 221–22 (1990); Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990). For civil detainees who have not been charged, tried, or adjudicated, the deprivation of representation, review, and bodily autonomy is even less defensible.

Procedural due process does not vanish at the threshold of psychiatry. It follows the person, not the diagnosis. And where the State denies both liberty and representation—while authorizing irreversible medical interventions without ever presenting its case to a judge—the Constitution requires more, not less. CRS § 27-65-106 fails that test. Its design suppresses challenge, conceals error, and collapses the adversarial safeguards due process demands.

CRS § 27-65-106 does not merely fall short of due process—it extinguishes it. In bypassing judicial review, undermining appointed counsel, and authorizing irreversible medical interventions based solely on untested allegations, the statute erects a civil regime more procedurally barren than the criminal system it purports to be distinct from. The Constitution does not flinch at labels; it looks to substance. And here, the substance is confinement without cause, treatment without consent, and silence without recourse. The Fourteenth Amendment guarantees more. Colorado law delivers less. This constitutional mismatch cannot be reconciled—it must be remedied.

Plaintiff's own experience illustrates how Colorado's involuntary hospitalization law (CRS § 27-65-105 at the time, now CRS § 27-65-106) operates not just unconstitutionally in theory, but abusively in practice. On August 8, 2013, after requesting clarification, Dr. Gareen Hamalian explicitly told Plaintiff that—in her medical opinion—Plaintiff was not a danger to himself, not a danger to others, and not gravely disabled. That conversation, contemporaneously documented by Plaintiff, rendered further detention legally and constitutionally unsupportable under the statute.

Plaintiff relayed this to his appointed attorney, who acknowledged that if the account was accurate, Plaintiff had been unlawfully detained. However, despite this admission—and despite being tasked with defending Plaintiff's rights—that attorney took no legal action to challenge the confinement.

On August 9, when Plaintiff reminded Dr. Hamalian of her statements from the day before, she claimed not to recall the conversation. Yet when asked again, she reiterated her clinical opinion: Plaintiff was not dangerous to self or others, and not gravely disabled.

That conversation, contemporaneously documented by Plaintiff, rendered further detention legally unsupportable and constitutionally barred. In Foucha v. Louisiana, 504 U.S. 71, 77–78 (1992), the Supreme Court held that continued confinement is impermissible unless the individual remains both mentally ill and currently dangerous. By Dr. Hamalian's own account, neither element was present.

Detention beyond that point was not a clinical error—it was a constitutional violation.

Despite these documented conversations, Plaintiff remained confined and was not released until August 13, 2013—days after Dr. Hamalian expressly denied any belief in Plaintiff's dangerousness or disability.At the time, false imprisonment for more than 12 hours without legal authority was classified as a felony in Colorado.

Compounding the harm, Plaintiff's attempt to protect his rights through documentation was actively thwarted. Colorado law granted him reasonable access to personal possessions, but his audio recorder—used to document provider interactions—was confiscated by hospital staff once they realized it was being used to capture an objective record of care. When Plaintiff refused to speak without a written transcript or a recording device, psychiatrists refused to communicate—until Dr. Jordan Gardner summoned Plaintiff to a conference room and threatened that continued silence would result in long-term certification.

This was not medical discretion—it was institutional extortion. The threat was clear: abandon your right to record—or face indefinite confinement. No neutral adjudicator was present. No counsel intervened. The legal standard for continued confinement had not been met. And yet, the silence of the record became the justification for continued seizure.

These facts are not peripheral—they are dispositive. They confirm that CRS § 27-65-106 not only enables constitutional deprivation, it actively suppresses the means of contesting it.

H. Continued Confinement Without Justification

Even if an initial detention meets constitutional standards, due process prohibits extending confinement without renewed justification. In Foucha v. Louisiana, 504 U.S. 71, 79–80 (1992), the Supreme Court held that continued involuntary confinement requires affirmative proof of present dangerousness, and that ongoing mental illness—without such a showing—cannot justify further deprivation of liberty.

In Foucha v. Louisiana, the Supreme Court made clear that the Constitution prohibits continued confinement absent current findings of danger. Where no such finding exists—as in Plaintiff's case—further detention is not merely unsupported; it is unconstitutional.

CRS § 27-65-106 flouts this requirement. It allows confinement to automatically extend from an initial 72-hour emergency hold to a 13-day hospitalization without:

Any new evidence,

Any judicial determination, or

Any reassessment of present risk.

This procedural gap is not minor—it is unconstitutional. Due process does not permit liberty to be curtailed on the basis of stale allegations or bureaucratic momentum. Without adversarial evaluation before a neutral decisionmaker, confinement ceases to be fact-based and becomes administrative imprisonment by default.

The Constitution demands more than a one-time affidavit; it requires that the basis for confinement continue to exist—and be demonstrated—at each stage of deprivation. Foucha makes this plain: “We cannot permit continued confinement on the basis of what might happen in the future,” absent current findings of danger. Id. at 79.

Addington established the evidentiary threshold: civil commitment demands clear and convincing proof of both mental illness and dangerousness. Mathews supplied the procedural test: the state must balance liberty, risk of error, and administrative burden to satisfy due process. Foucha confirmed the boundary: confinement cannot continue absent current proof of dangerousness. Yet the American Psychiatric Association—whose members are charged with generating such predictions—has declared this burden “impossible,” acknowledging in its Tarasoff amicus brief that psychiatrists are “ill-equipped to undertake” the task of reliably forecasting future dangerousness. CRS § 27-65-106 violates each standard in turn. It authorizes confinement without sufficient evidence, sustains it without adequate process, and prolongs it even after danger is affirmatively ruled out. The result is not merely an occasional error—it is a systemic inversion of constitutional order."

CRS § 27-65-106 violates each standard in turn. It authorizes confinement without sufficient evidence, sustains it without adequate process, and prolongs it even after danger is affirmatively ruled out. This is not a statute that balances constitutional protections against state interests—it is a legislative bypass of the very safeguards that define liberty in American law. It does not merely fail to satisfy due process; it suppresses it. The result is not occasional error but sustained constitutional inversion. Under the Supremacy Clause, such a law cannot stand.

I. Unlawful Confinement, Forced Injection, and the Right to Self-Defense

On August 1, 2013—the very day Plaintiff was seized and hospitalized—he was forcibly injected with the antipsychotic drug Zyprexa, without consent, without a court order, and without any judicial finding of incapacity or danger. The physician who ordered the injection was not Dr. Gareen Hamalian, and the paperwork used to justify it alleged no clinical emergency, only that Plaintiff was “calm". No hearing occurred. No neutral decisionmaker intervened. The injection was carried out while Plaintiff was strapped

to a gurney, and just before Plaintiff lost consciousness, one staff member asked, “Is this okay?”, to which another responded, “Yeah, he’s been transported before.” The exchange illustrates the culture of normalized coercion and disregard for legal boundaries.

Plaintiff was rendered unconscious in Loveland and regained consciousness in Denver—having been transported across jurisdictions while sedated and physically restrained, without consent, without judicial authorization, and without lawful clinical justification. Under Colorado law, such movement of an individual without lawful authority or consent constitutes second-degree kidnapping. C.R.S. § 18-3-302(1). The transport was not necessitated by medical need; it was an extension of unlawful detention, executed covertly and without due process.

Several days later, on August 8, 2013, Dr. Hamalian explicitly told Plaintiff that, in her clinical opinion, he was not a danger to himself, not a danger to others, and not gravely disabled. Plaintiff contemporaneously documented that conversation. When reminded of it the following day, Dr. Hamalian did not recall making those statements, but after being asked again, she reaffirmed that Plaintiff did not meet any of the statutory criteria for continued confinement. Despite these statements, Plaintiff remained confined for five more days—without any judicial finding, documentation of danger, or emergent circumstances.

Under Colorado law, false imprisonment becomes a felony when it extends beyond twelve hours and lacks lawful authority. C.R.S. § 18-3-303. Any use of physical force during such confinement—including forced medication—constitutes unlawful force under C.R.S. § 18-1-704 and triggers the right to self-defense. Colorado law does not require a person to submit to unauthorized bodily intrusion. It allows for reasonable force to resist it.

Even convicted prisoners retain a right to refuse medical treatment unless and until a neutral decisionmaker finds legal incapacity or imminent danger. Washington v. Harper, 494 U.S. 210, 221–22 (1990); Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 278 (1990). Plaintiff, by contrast, had not been convicted, not been charged, and—according to the evaluating psychiatrist—not even been dangerous or gravely disabled.

The injection on August 1 was not therapeutic. It was a constitutional and statutory violation—a form of battery under color of law. CRS § 27-65-106 offers no meaningful safeguards to prevent such acts. It enables seizure and chemical restraint without probable cause, without hearings, and without any mechanism for timely objection. A regime that allows such acts to proceed in silence is not merely flawed—it is lawless.

Moreover, if the government's asserted interest lies in protecting public safety, then placing patients in legally ambiguous scenarios that justify self-defense—such as unauthorized physical intrusion and

chemical restraint—undermines that interest outright. It endangers not only patients, but clinicians and staff, by manufacturing conditions in which reasonable resistance becomes legally defensible. Safety cannot be served by creating conflict.

There is also a deeper psychological and social cost. Many patients enter psychiatric care believing in the fundamental principle that everyone has equal rights under the law. But when the system demonstrates—through coercion, silencing, and violation—that such rights can be selectively suspended or discarded, it teaches a darker, corrosive lesson: that law is merely power in disguise. From that premise, a logic emerges that if one person has no rights, perhaps no one truly does. For those already vulnerable or disenfranchised, this revelation can be destabilizing, alienating, and, in some tragic cases, radicalizing.

If psychiatric policy teaches that law exists to be broken by institutions but obeyed by the powerless, then the social contract itself is fractured. And when patients experience flagrant illegality while confined—especially under the color of care—their future relationship to law, society, and self-governance is poisoned. We should not be surprised that some who survive that experience view laws as negotiable, or justice as a fiction. The roots of violence sometimes lie not in madness, but in betrayal.

J. Harper as a Constitutional Floor—Not a Ceiling

The Supreme Court's decision in Washington v. Harper, 494 U.S. 210 (1990), has often been invoked to justify forced psychiatric medication without prior judicial authorization. Yet even Harper—decided in the context of convicted prisoners—demands more than what CRS § 27-65-106 provides. The constitutional minimalism upheld in Harper was premised on the assumption of criminal conviction, institutional custody, and the availability of structured internal review. Civil detainees held under Colorado's statute are entitled to more, not less.

In Harper, the Court sustained a policy allowing prison officials to administer antipsychotic medication without a judge's approval—but only under narrowly circumscribed conditions: a structured hearing before a neutral medical panel, notice and the opportunity to present evidence, an independent lay advisor, a written decision, and periodic review. These safeguards were grounded in the custodial context of penal confinement and expressly tailored to its administrative realities.

CRS § 27-65-106 supplies none of these. It offers no hearing, no neutral body, no advisor, no formal record, and no post-hoc review of involuntary medication decisions. The statute thus fails even the Harper baseline—furnishing civil detainees with fewer procedural protections than convicted criminals. Whatever force Harper has in defining the outer constitutional limits of forced treatment, it cannot license a regime where medication is administered unilaterally, invisibly, and without recourse. That is not merely below

the line—it is beneath constitutional dignity.

K. Delegation Without Adjudication: Reconsidering Harper's Premise

Even if Harper is taken at face value, it invites serious reconsideration. The Constitution vests the adjudicative power to deprive an individual of liberty or bodily integrity in courts—not in hospital administrators or clinical staff. Harper blurred this line, allowing executive branch actors—operating without judicial supervision—to authorize profound deprivations of autonomy. In doing so, it redefined what counts as due process not by elevating rights, but by lowering institutional expectations.

This delegation of judicial function to private or executive actors is especially problematic when transplanted into a civil framework. Civil detainees, unlike prisoners, have not forfeited rights through conviction. They retain their full constitutional protections, including the right to bodily integrity, presumed competence, and the presumption of liberty. To afford them fewer safeguards than incarcerated individuals—and to justify it by reference to Harper—is to convert administrative convenience into constitutional substance.

But due process is not a doctrine of convenience. It is a doctrine of limits—on power, on discretion, and on the substitution of medical opinion for legal judgment. If Harper erred, it did so by allowing treatment decisions of constitutional magnitude to proceed without neutral adjudication. CRS § 27-65-106 compounds that error by offering no adjudication at all.

III. Witnessed Death and the Irreversible Consequences of State-Imposed Treatment

In 2013, during a 13-day involuntary confinement at Denver Health, Plaintiff witnessed the death of a fellow detainee—an elderly man who collapsed and died during lunch. Just minutes earlier, the man had asked Plaintiff to help open a mustard packet. Plaintiff assisted him, finished his meal, and returned to his room. Moments later, a commotion erupted. The man had lost consciousness. Nurses brought in a crash cart, but resuscitation efforts failed. He died in the cafeteria. His passing received no public notice. But it did not go unwitnessed. Plaintiff was the last person the man spoke to while alive.

Plaintiff does not possess medical records confirming what medications the man received. However, based on firsthand observation of facility practice, Plaintiff believes it was common for detainees to be medicated with antipsychotic drugs such as haloperidol and olanzapine. These medications are known to prolong the QT interval between heartbeats, significantly increasing the risk of fatal cardiac arrhythmias—particularly in elderly or medically vulnerable individuals. See Ray et al., “Antipsychotic Drugs and the

Risk of Sudden Cardiac Death," New England Journal of Medicine 360:225–235 (2009). The man who died appeared physically frail. Yet, so far as Plaintiff is aware, there was no hearing and no judicial oversight prior to his detention or medication, nor any external review following his death.

And the medical risks posed by these drugs are not confined to the heart. A substantial and growing body of peer-reviewed research confirms that long-term use of neuroleptics causes irreversible structural damage to the brain, particularly in the frontal cortex, basal ganglia, and temporal lobes. See Ho et al., "Long-term Antipsychotic Treatment and Brain Volumes," Archives of General Psychiatry 68(2):128–137 (2011); Moncrieff & Leo, "A Systematic Review of the Effects of Antipsychotic Drugs on Brain Volume," Schizophrenia Research 79 (2005):105–124. Neuroimaging studies have shown measurable reductions in gray matter volume and neuronal density linked directly to cumulative exposure. These changes are not transient side effects—they are permanent injuries that impair cognition, motivation, and self-determination. They compromise the foundational substrates of human agency.

When such brain-altering chemical restraints are imposed without probable cause, without judicial process, and without informed consent, the violation transcends medical malpractice. It becomes constitutional in nature. Involuntary psychiatric drugging, when not authorized by lawful adjudication, constitutes not a therapeutic act—but a state-sponsored battery. And when the result of such confinement is death, the constitutional stakes multiply.

If the man who died was confined without probable cause—under the statutory scheme codified at the time as CRS § 27-65-105—his detention may have constituted false imprisonment under Colorado law as it existed in 2013. If that confinement exceeded twelve hours, it could satisfy the elements of felony false imprisonment, a class 5 felony during that period. If that detention involved transportation to Denver Health against his will, it could also satisfy the statutory elements of second-degree kidnapping. And if death occurred during the commission of either of those felonies, then under C.R.S. § 18-3-102(1)(b) (2013), such a death would constitute first degree felony murder—a crime not subject to any statute of limitations and not dependent on intent to kill.

Even if statutory definitions or classifications have changed in subsequent years, those changes do not retroactively govern this case. The Ex Post Facto Clause of the United States Constitution (Article I, Section 9) prohibits retroactive application of laws that redefine crimes, reduce the evidentiary threshold for conviction, or alter the legal consequences of conduct after it occurs. Accordingly, the definitions in effect in 2013 are legally controlling.

Moreover, the legal implications may extend beyond state law. Under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961–1968, a pattern of racketeering activity requires at least two predicate acts within a 10-year span, one of which must still be chargeable. Felony false

imprisonment or second-degree kidnapping—as defined under Colorado law in 2013—qualify as predicate acts under RICO. And first-degree felony murder, which remains chargeable due to the absence of a statute of limitations, may serve as the second predicate. If these acts were committed through a coordinated institutional process—such as involuntary transport, confinement, and medication imposed under color of law—then the statutory criteria for a RICO violation may be satisfied.

This brief does not allege a criminal offense. Rather, it preserves the legal record: that an individual may have died—confined and medicated without judicial authorization—under a statutory framework that cannot withstand constitutional scrutiny. His name may be absent from the official record, but the circumstances of his death cannot be dismissed. The harm inflicted by such statutory schemes is not theoretical; it is real, lived, and measurable. It penetrates both body and mind at the molecular level, altering biological structure and cognitive function without notice, consent, or lawful justification. The damage is irrevocable. And where the courts fall silent in the face of violations against the supreme law of the land, the duty to bear witness falls to the record itself.

The Constitution does not permit the state to inflict death without accountability. Nor does it allow history to erase those silenced without process. This record does not seek punishment. It seeks remembrance.

IV. Additional Constitutional Violations

In addition to the foundational procedural and Fourth Amendment violations identified above, CRS § 27-65-106 implicates several other constitutional doctrines that merit recognition and preservation for future adjudication.

A. Substantive Due Process and Bodily Integrity

The Fourteenth Amendment protects the fundamental right of competent adults to refuse unwanted medical treatment—a principle firmly rooted in Anglo-American common law and constitutionally affirmed in Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990). That right applies with full force even in the prison context, as recognized in Washington v. Harper, 494 U.S. 210, 221–22 (1990). The doctrine of bodily integrity bars state actors from imposing medical interventions—especially those that alter brain chemistry—absent due process and judicial safeguards.

Yet under CRS § 27-65-106, individuals may be forcibly medicated based solely on a clinician's unreviewed judgment of "danger," without a court order, a formal capacity hearing, or any documented risk–benefit assessment. This authority permits staff to override a competent adult's medical refusal

through extrajudicial means, sometimes repeatedly, and often without triggering any later review. Such state-sanctioned intrusion—especially through antipsychotics known to impair cognition and blunt volition—constitutes more than overreach. It is a direct violation of substantive due process and the constitutional guarantee of personal sovereignty over one's own body.

B. Statutory Conflict: Right to Refuse Treatment Under Colorado Law

CRS § 15-14-504 affirms a fundamental principle of medical ethics and personal autonomy: every competent adult in Colorado has the right to refuse medical intervention, regardless of risk or provider judgment. This statutory protection is not advisory—it reflects a deep common law tradition, constitutionally reinforced by Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990), and binding unless overridden by a court finding of incapacity or lawful guardianship.

CRS § 27-65-106, however, functionally nullifies this safeguard. It empowers clinicians to override a competent individual's refusal of care—including invasive psychotropic interventions—without a prior judicial determination of incapacity, and without affording the individual any opportunity to contest that override. In doing so, it transforms a statutory right into a discretionary suggestion and places final authority over bodily autonomy in the hands of non-judicial actors.

This is not a mere internal contradiction—it is a structural conflict that collapses the patient's legal dignity. The State cannot simultaneously guarantee the right to refuse treatment and authorize its circumvention by fiat. If § 15-14-504 is to have any meaning, § 27-65-106 must be limited—or struck—to ensure that constitutional and statutory rights do not dissolve in the fog of clinical discretion.

C. Equal Protection Violation

CRS § 27-65-106 imposes a distinct and unequal legal regime upon individuals with actual or perceived mental health diagnoses, subjecting them to non-criminal detention based not on conduct, but on predictive assumptions. This statutory structure facially classifies individuals on the basis of disability—specifically psychiatric disability—and then deprives them of liberty without the procedural or evidentiary standards required in any other context.

In City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 442–44 (1985), the Supreme Court held that laws singling out those with intellectual and mental disabilities for disfavored treatment must be justified by legitimate state interests and may not rest on irrational prejudice or stereotypes. CRS § 27-65-106 fails that test. It codifies the presumption that people with psychiatric diagnoses are uniquely dangerous—a

determination made without individualized evidence and applied without judicial supervision. Such treatment would not be imposed on similarly situated individuals absent a diagnostic label, even if their behavior were identical.

Equal protection requires that governmental classifications be both neutral and proportionate. Yet CRS § 27-65-106 establishes a two-track justice system: one where rights are preserved for the "mentally well," and another where they are suspended for the "psychiatrically labeled." The deprivation of liberty in this second track occurs without criminal charge, hearing, or evidentiary process—triggered solely by diagnostic status.

That is not equal protection. It is legally sanctioned discrimination dressed in clinical garb. And it is flatly incompatible with the Fourteenth Amendment.

D. The Eighth Amendment and the Medical Right Not to Be Harmed

The Eighth Amendment's ban on "cruel and unusual punishments" traditionally governs two categories of constitutional injury: the deliberate infliction of harm and the deliberate denial of necessary care. Yet a third, less conventional—but no less injurious—category exists: the imposition of invasive, degrading, or unnecessary procedures under the guise of medical treatment. Where the State purports to help but, in truth, causes harm, it does not evade Eighth Amendment scrutiny—it invites it.

The Supreme Court has repeatedly affirmed that "deliberate indifference to serious medical needs" violates the Eighth Amendment. Estelle v. Gamble, 429 U.S. 97, 104 (1976); Helling v. McKinney, 509 U.S. 25, 33 (1993). But the "serious medical need" at issue need not be for active treatment. It may, instead, be the need not to be subjected to physically invasive or neurologically destructive procedures. Just as a person has a medical need not to be decapitated, a mental health patient may have a medical need not to be forcibly injected with drugs that chemically mutilate the brain.

This principle acquires heightened urgency in the context of Colorado's emergency drugging statute, CRS § 27-65-106. Under this regime:

Individuals may be forcibly injected with powerful neuroleptics—such as haloperidol and olanzapine (Zyprexa)—without a hearing, without consent, and without even a documented finding of incapacity.

These interventions occur before any evidentiary hearing, outside judicial review, in clinical environments that function as proxy detention centers.

The medications involved are not benign: peer-reviewed studies and neuroimaging research confirm that these drugs can cause irreversible neuronal atrophy, particularly in the frontal lobes—the region of the

brain governing motivation, agency, and the capacity to experience pleasure. These effects are not therapeutic. They are injurious.

Indeed, in some cases, the side effects are the constitutional harm. When the State destroys the neurobiological substrate of volition itself, the result is not healing—it is mutilation. Far from addressing a medical condition, the treatment becomes the injury. What is imposed is not medicine but mechanized degradation—an involuntary alteration of mood, cognition, and identity—without due process, without informed consent, and without medical necessity grounded in clear and convincing evidence.

In this way, the argument reframes the Eighth Amendment violation: not as a failure to treat, but as a transgression of the boundaries of permissible treatment. The patient's brain becomes the site of constitutional violation. And the violation is not theoretical—it is chemical, experiential, and enduring.

Such acts are neither benign nor therapeutically neutral. When administered absent standards, oversight, or adjudication, these forced medical interventions become a form of punishment. Their cruelty is not simply "unusual"; it is extrajudicial—imposed without accountability and outside the bounds of any lawful order. The Constitution does not permit the State to swap prison bars for hospital beds and call it care. Nor may it disguise a chemical lobotomy as "emergency medicine" simply because the scalpel has been traded for a syringe.

The power to destroy the mind in the name of preserving it is not therapeutic—it is totalitarian. The Eighth Amendment forbids it.

E. Violation of the Free Exercise Clause: Religious Objections to Involuntary Psychiatric Detention and Drugging

1. Doctrinal Context: The Body as Sacred Space

Scripture warns of a time when the "abomination that causes desolation" will stand in the holy place (Daniel 9:27; Matthew 24:15)—a prophetic desecration of what is most sacred. The New Testament reinterprets that "holy place" not as a structure of stone, but as the human body:

"Or do you not know that your body is a temple of the Holy Spirit within you, whom you have from God?" — 1 Corinthians 6:19

"If anyone destroys God's temple, God will destroy him. For God's temple is holy, and you are that temple.— 1 Corinthians 3:17

For many believers, this is not metaphor but identity. The sanctity of the body—especially the mind, understood as the seat of volition and spirit—is theologically inviolable. Accordingly, any state-mandated intervention that chemically alters cognition, agency, or consciousness may be understood not as treatment, but as spiritual desecration. The parallel to prophetic warning is not rhetorical flourish—it is doctrinal conviction. And where such conviction is sincerely held, it falls squarely within the protections of the First Amendment.

2. Legal Framework: Free Exercise of Religion and Bodily Autonomy

The Free Exercise Clause bars the government from substantially burdening religious belief or practice absent a compelling interest pursued through the least restrictive means. Courts have recognized this protection applies even when the religious belief diverges from mainstream orthodoxy. The protected rights include:

Refusal of unwanted medical treatment on spiritual or religious grounds. Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990);

Preservation of bodily integrity as a dimension of spiritual autonomy. Washington v. Glucksberg, 521 U.S. 702 (1997);

Protection of sincerely held belief, regardless of theological uniformity. Thomas v. Review Board, 450 U.S. 707 (1981).

Forced neuroleptic drugging—especially when objected to on the ground that it constitutes defilement of the "body-temple"—imposes a profound spiritual burden. Such objection, even if individually held, falls within the zone of religious conscience that the First Amendment was designed to shield.

3. Strict Scrutiny: A Constitutional Threshold the State Cannot Meet

When the government imposes a substantial burden on religious exercise, it must satisfy strict scrutiny. This requires:

A compelling governmental interest, such as preventing immediate physical harm; and

That the policy be executed through the least restrictive means available.

The Colorado statutory scheme codified in CRS § 27-65-106 fails both prongs:

It authorizes forced administration of neuroleptic drugs without any judicial finding of legal incapacity or

imminent danger;

It imposes irreversible cognitive, neurological, and spiritual injury, despite the availability of alternative procedures, such as judicial review or less invasive interventions.

The burden is not merely theoretical: for persons who understand their mind as a sacred locus of divine presence, compelled chemical alteration is a forced spiritual transgression. The state's refusal to explore alternatives renders its action not only constitutionally deficient—it renders it spiritually unconscionable.

4. Failure of Strict Scrutiny and the Religious Imperative of Truth-Preservation

When the government substantially burdens a sincerely held religious belief, it must satisfy the strictest standard of constitutional review. Under the First Amendment, such a burden is permissible only if the government demonstrates:

A compelling interest—such as preventing imminent harm or protecting the rights of third parties; and

That the infringement is the least restrictive means of advancing that interest.

Psychiatric facilities may cite patient privacy as justification for prohibiting the use of personal audio recording devices. Yet that rationale collapses under constitutional scrutiny when a less restrictive—and constitutionally adequate—alternative exists: permitting the individual to withdraw from the setting altogether.

CRS § 27-65-106 authorizes confinement even in the absence of a judicial finding of incapacity or danger. Continued confinement in such cases is discretionary, not mandatory. If an individual's religious belief mandates continuous audio recording as a form of spiritual truth-preservation, and the facility asserts that such activity violates institutional privacy protocols, then the asserted government interest is not absolute—it is conditional upon a liberty deprivation of the state's own making.

The least restrictive means of reconciling the asserted privacy concern is not the confiscation or disabling of a religious instrument. It is release. To deny an individual both the right to religious practice and the right to depart is not an exercise in constitutional balance—it is an act of coercion, one made possible only by the prior seizure of liberty and leveraged to suppress spiritual conscience.

This rationale is circular. The government first extinguishes the individual's freedom of movement, then invokes the proximity to others within that confinement as a basis for overriding religious freedom. The conflict is not intrinsic—it is constructed. And once constructed, it is wielded against the believer.

Critically, this burden falls upon those who view the preservation of truth not merely as a civic virtue but

as a sacred duty. Scripture identifies truth not only as a moral ideal, but as a living reality:

“I am the way, and the truth, and the life.” — John 14:6

In this proclamation, Christ does not describe truth as an abstract principle but as His very essence. For believers who interpret this mandate literally, the pursuit and preservation of truth is a spiritual vocation. It is not optional.

Jesus reinforced this principle through the parable in Matthew 13:52:

“Therefore every scribe who has been trained for the kingdom of heaven is like a master of a house, who brings out of his treasure what is new and what is old.”

This passage describes the sacred responsibility of those entrusted with divine knowledge: they must be able to preserve, access, and deliver truth across time. In a modern context, the “treasure” and “storehouse” of that parable may be understood to include digital archives—such as audio recordings securely stored on a hard drive. For adherents who see themselves as scribes of the kingdom, the act of continuous recording is not incidental to their belief—it is central to it. It is, in effect, a spiritual logbook: a record of lived truth, safeguarded against distortion, misremembering, or institutional erasure.

Accordingly, the confiscation or disabling of such a device is not a neutral administrative act. It is the suppression of a religious instrument, rooted in theology, doctrine, and practice. Where the recording serves solely to preserve one’s own experience—and not to surveil or disseminate the speech of others—its restriction cannot be justified as an institutional necessity.

To prohibit a believer from documenting truth in precisely the environment where truth is most vulnerable to distortion is to deny them the tools of spiritual fidelity. The Constitution does not permit that denial. Nor does it allow the state to manufacture the constitutional conflict by seizing liberty and then using the artificial consequences of confinement to negate religious conscience.

When a less restrictive means—such as voluntary discharge—would fully vindicate both liberty and religious expression, the imposition of a greater burden fails not only the Free Exercise Clause, but strict scrutiny as a whole.

5. Conclusion: Constitutional Boundaries and the Sanctity of Conscience

The burdens imposed by CRS § 27-65-106 are not hypothetical, nor are the beliefs it infringes mere theological abstractions. For those who understand their bodies as sacred vessels—whose religious convictions require them to preserve the integrity of their mind and to maintain a record of truth as part of

a spiritual mandate—the statute authorizes precisely what the Constitution prohibits.

The Free Exercise Clause does not tolerate spiritual violation under the guise of medical necessity. It forbids the state from compelling the surrender of conscience, whether through forced neurochemical alteration or the suppression of religious instruments used to safeguard one's spiritual memory. The fact that these violations occur in a civil psychiatric context does not diminish the burden; it magnifies it.

CRS § 27-65-106 empowers the state to detain, drug, and silence persons who have neither been convicted of crime nor adjudicated incompetent—then invokes the logistics of that detention to justify the overriding of spiritual autonomy. But the First Amendment draws a clear and impenetrable boundary around the domain of conscience. Where the state possesses less restrictive means to serve its asserted interests—such as voluntary discharge or adversarial review—but declines to use them, it ceases to act as guardian and instead assumes the role of violator.

Conscience cannot be overridden by convenience. Religious fidelity cannot be forfeited to administrative expediency. And sacred truth cannot be erased by institutional preference.

The Constitution is not advisory in such matters. It is binding. And where religious liberty collides with coercive power, it is the liberty that must prevail.

V. Criminal Liability and Constitutional Consequences

Though styled as civil legislation, CRS § 27-65-106 functions as more than a policy misstep—it may constitute active participation in a federal criminal conspiracy to violate constitutional rights. By authorizing nonconsensual confinement and forced drugging absent any judicial findings of criminal guilt or legal incompetence, the statute crosses the line from mere constitutional infirmity to potential criminal culpability. State officials who knowingly design, enforce, or participate in such a regime risk personal liability under federal civil rights statutes. Claims of sovereign or judicial immunity do not shield such conduct where Congress has validly exercised its enforcement authority.

A. Conspiracy to Violate Civil Rights — 18 U.S.C. § 241

Federal law makes clear: "[i]f two or more persons conspire to injure, oppress, threaten, or intimidate" any individual in the free exercise of their constitutional rights, they commit a federal crime. 18 U.S.C. § 241. This prohibition extends to state officials—including legislators, law enforcement, and clinical personnel—acting under color of law. It does not require that the rights violation succeed; the conspiracy

and overt acts alone are sufficient.

CRS § 27-65-106 authorizes seizures without probable cause, medical interventions without judicial oversight, and liberty deprivations absent any adversarial review. These acts plainly violate the Fourth and Fourteenth Amendments. The statute's architects and enforcers acted with full awareness of its constitutional infirmities. They moved forward anyway—deliberately targeting a politically marginalized population through a regime built on diagnostic profiling, speculative psychiatric prediction, and the systematic denial of procedural safeguards.

In Colorado, the confinement of a competent adult without legal authority may qualify as false imprisonment or second-degree kidnapping under CRS § 18-3-303. When carried out under color of law and in coordination with others, it satisfies the core elements of a conspiracy under § 241. Where such detention results in death—as has occurred in cases involving forced drugging or excessive restraint—§ 241 authorizes life imprisonment or capital punishment.

This is not abstract liability. The conduct is codified in statute, deliberate in design, and executed through coordinated action. Section 241 does not require success—only agreement and overt act. Both are evident here. And both fall squarely within the reach of federal criminal law.

B. Limits of Sovereign and Judicial Immunity

Federal criminal liability under 18 U.S.C. § 241 is not constrained by doctrines of state sovereign immunity. Pursuant to the Supremacy Clause (U.S. Const. art. VI) and Section 5 of the Fourteenth Amendment, Congress possesses the authority to enact criminal statutes that bind state actors, even when those statutes override state prerogatives. As reaffirmed in Fitzpatrick v. Bitzer, 427 U.S. 445, 456 (1976), Congress may abrogate state immunity to enforce constitutional guarantees.

Accordingly, while a state as an entity cannot be indicted, individual officials—including legislators, agency heads, law enforcement personnel, medical professionals, and under certain conditions, judges—may face personal criminal exposure under § 241 when they knowingly participate in schemes to deprive individuals of their constitutional rights.

That exposure includes lawmakers themselves. By voting to enact CRS § 27-65-106 in full awareness of its procedural deficiencies—particularly its authorization of seizures without probable cause—legislators committed an overt act in furtherance of a statutory framework that deliberately lowers the Fourth Amendment threshold. The statute substitutes clinical "dangerousness" for the constitutional requirement of "a reasonable ground for belief of guilt" (Brinegar v. United States, 338 U.S. 160, 175 (1949))—thereby authorizing non-criminal deprivation of liberty based on predictive speculation rather than

judicially admissible evidence. That departure from constitutional standards is not incidental; it reflects a coordinated agreement between lawmakers and medical actors to prioritize discretionary detention over individual rights, satisfying the agreement element of a rights-deprivation conspiracy under § 241.

Judges are likewise not categorically immune. While absolute judicial immunity protects core adjudicatory functions in civil contexts, it does not insulate judges from criminal liability when they act in coordination with others to perpetuate unconstitutional schemes. For example, when judicial officers routinely extend emergency holds without hearings, without capacity findings, and without adversarial review—functioning as rubber stamps for hospital requests rather than as neutral arbiters—they risk stepping outside their judicial role and into extrajudicial collaboration. When that pattern is sustained with knowledge of constitutional deficiency, it may qualify as an overt act within a broader criminal conspiracy.

In sum, CRS § 27-65-106 is not merely a policy misjudgment—it is a mechanism of collective deprivation, carried out with knowledge of its illegality, against a legally and politically vulnerable class. The enforcement of such a framework—particularly by those with power to codify, implement, or extend it—is not protected by immunity. It is potentially prosecutable under federal law.

C. Legislative Time-Barriers as Violations of the Right to Petition and Due Process

Statutes of limitations and governmental immunity laws—such as the Colorado Governmental Immunity Act (CGIA)—are often framed as neutral procedural rules. But when applied to constitutional injuries arising in contexts of concealment, medical misclassification, or judicial bypass, these statutes functionally abridge the First Amendment rights to peaceably assemble and to petition the government for a redress of grievances.

“Congress shall make no law... abridging the freedom... of the people peaceably to assemble, and to petition the Government for a redress of grievances.” —U.S. Const. amend. I

A civil rights lawsuit alleging unlawful detention, forced drugging, or institutional abuse is not a private tort—it is a constitutional petition for public accountability. When statutes like CGIA’s six-month deadline are enforced before the victim can obtain records, secure counsel, or even comprehend the legal character of their injury, they operate not as procedural filters, but as silencers of redress. They punish disenfranchisement with preclusion.

This silencing is compounded when state action takes place within frameworks of concealment and mischaracterization. Three examples are illustrative:

1. Medicalization

Medicalization occurs when the State frames a liberty-depriving act as a clinical one. What is in substance detention becomes “treatment”; what is coercion is labeled “care.”

Why it matters: This framing obscures constitutional triggers. When a person is seized, drugged, or confined under medical labels, courts frequently bypass Fourth and Fourteenth Amendment scrutiny—ignoring the need for probable cause, judicial review, or adversarial process. Medicalization enables the government to exercise carceral power while escaping judicial accountability. It is not merely mislabeling—it is the conversion of coercive force into language courts refuse to question.

2. Concealed Detention

Concealed detention refers to liberty deprivation that avoids recognition as such. It occurs when:

Emergency holds are filed by clinicians without judicial review;

Private facilities impose confinement with no adversarial process;

Individuals are misclassified as “voluntary” while confined under threat or coercion.

Why it matters: These practices allow the State to detain individuals without acknowledging the detention as such—sidestepping the legal and constitutional requirements that attach to confinement. The result is institutional incarceration without the name, and without the process. This detention produces all the harms of incarceration—loss of liberty, forced compliance, stigma—without the protections the Constitution mandates.

3. Judicial Bypass and Record Obstruction

Where courts deny legal representation, and institutions withhold critical records—as occurred in this case—individuals are not merely disadvantaged, they are structurally denied access to adjudication. There is no opportunity to preserve the constitutional record at the time of injury. And with no record, the window for redress quietly closes.

Why it matters: Victims are left without any legal signal or procedural gateway to assert their rights before the limitations period expires. The path to challenge is not merely difficult—it is invisible.

When statutes of limitation are enforced under these conditions, they protect not against stale claims, but against public accountability. They serve not efficiency, but impunity.

“A law repugnant to the Constitution is void.” —Marbury v. Madison, 5 U.S. 137, 177 (1803)

Statutory time bars that extinguish redress before it is accessible—especially where the State obscures the

harm and controls the means of proof—are not constitutional. They violate not only the First Amendment right to petition, but also the due process guarantees of the Fourth and Fourteenth Amendments. Where the State is both the perpetrator and the gatekeeper of redress, courts may not permit it to silence constitutional grievance by running out the clock.

D. Economic Disenfranchisement, Denial of Counsel, and Access Barriers

Access to justice depends not merely on awareness of injury, but on the ability to act upon it—through legal assistance, access to evidence, and a fair procedural footing. In this case, Plaintiff lacked the sustainable financial capacity to retain competent legal counsel for the duration and complexity of constitutional litigation. Although it may have been possible to hire an attorney briefly by liquidating essential personal property, such representation could not have been sustained long enough for counsel to meaningfully investigate, understand, and litigate the claims involved.

At the sole hearing in this matter, Plaintiff moved for appointment of counsel. That motion was denied. Without legal representation, Plaintiff was unable to compel the Court to address the threshold constitutional question on which all further analysis hinged: whether Colorado Revised Statutes § 27-65-105 authorized police seizure absent probable cause. Because that question went unanswered, the constitutional defect at the heart of the claim was never adjudicated and the record was left undeveloped.

Further compounding this exclusion was Plaintiff's limited ability to gather and understand critical facts. Denver Health, a publicly affiliated institution, delayed release of medical records that contained evidence essential to assessing the nature and scope of the constitutional violation. Although those records were not requested within the CGIA's six-month notice period, the omission must be understood not as neglect, but as the consequence of prolonged economic and procedural blockade. In truth, Plaintiff did not seek release of the medical records until it became undeniably clear—after years of unresolved disputes with credit reporting agencies—that the hospitals responsible for the unconstitutional confinement would not remove the corresponding medical debt from Plaintiff's credit report unless compelled by formal legal action. All other avenues of resolution were exhausted, and the reporting institutions refused to comply with their obligations under federal law requiring investigation of disputed claims. Legal process became the only available tool of redress.

This broader issue has since been recognized at the legislative level. In 2023, the Colorado General Assembly enacted HB23-1126, which prohibits the placement of medical debt on consumer credit reports. This statute reflects a growing acknowledgment that healthcare billing practices—especially those unaccompanied by express consent or judicial judgment—routinely inflicted economic harm and reputational damage on Coloradans. The law's passage offers tacit validation of Plaintiff's position: that

the conduct at issue was not isolated but indicative of a statewide pattern of coercive billing practices, frequently lacking informed agreement or lawful adjudication.

In effect, the CGIA clock began ticking while the Plaintiff stood outside the courthouse—unrepresented, unequipped, and uninformed, with the evidence of constitutional harm hidden behind institutional noncompliance and economic leverage.

The Supreme Court has long warned against structural exclusion from the courts. In Bounds v. Smith, 430 U.S. 817, 828 (1977), the Court held that even convicted prisoners must be afforded meaningful access to the judicial process—including the legal tools and assistance necessary to challenge the conditions of their confinement. But civil detainees under CRS § 27-65-106, though accused of no crime, are routinely denied any such access. They may be seized, forcibly medicated, and discharged without ever appearing before a judge or receiving an opportunity to contest their detention. This asymmetry is not just troubling—it inverts constitutional logic. The State provides procedural safeguards to those it has convicted, yet withholds them from individuals it has never charged. That is not merely a procedural gap; it is a constitutional contradiction the Fourteenth Amendment cannot permit.

In Griffin v. Illinois, 351 U.S. 12 (1956), the Court held:

"There can be no equal justice where the kind of trial a man gets depends on the amount of money he has."

And in Bounds v. Smith, 430 U.S. 817 (1977), the Court confirmed that meaningful access to the courts is itself a constitutional requirement.

Here, the denial of counsel, the inability to compel judicial engagement, the obstruction of records, and the enforcement of a rigid statutory deadline worked together to eviscerate Plaintiff's constitutional right to petition. This was not administrative friction—it was constitutional disenfranchisement. When the State denies both the tools and the opportunity for redress, then invokes "untimeliness" as a shield against its own liability, it is not administering justice. It is securing impunity by design.

That violates both the Due Process Clause of the Fourteenth Amendment and the First Amendment's command that: "Congress shall make no law... abridging... the right of the people... to petition the Government for a redress of grievances."

VI. Empirical and Public Safety Failures

While CRS § 27-65-106 purports to serve public safety by preemptively detaining those labeled "dangerous," the empirical evidence undercuts its efficacy and reveals systemic harm. Rather than

reducing violence or protecting communities, the statute misallocates state power—displacing criminal accountability with speculative civil confinement and undermining both justice and public trust.

A. Lack of Evidence for Violence Prevention

Civil commitment statutes like CRS § 27-65-106 are not supported by reliable data demonstrating a meaningful reduction in crime or violence. Multiple national studies have revealed that involuntary psychiatric hospitalization shows no statistically significant impact on preventing interpersonal violence, and in many cases, exacerbates long-term instability. As researchers have noted, involuntary holds often result in "revolving-door" outcomes—where individuals are detained, discharged without meaningful care, and repeatedly recycled through the system with little benefit to public or personal safety.

This model comes at a steep cost. It diverts scarce mental health resources away from voluntary, community-based interventions that do have proven impact—such as mobile crisis teams, supportive housing, and trauma-informed outreach. Instead, funding is funneled into short-term coercive care, which imposes trauma on the detained and burden on the taxpayer, without demonstrable returns. In effect, the statute punishes the innocent and disables effective safety systems—while giving the illusion of action.

B. Illustrative Case Studies: McClain, Glass, and the Parkland Exception

CRS § 27-65-106 and similar statutes have left the realm of policy theory; their harms are real, recurring, and deadly.

Elijah McClain (2019): McClain was walking home when approached by police due to reports that he "looked suspicious." Despite committing no crime, he was forcibly detained, injected with ketamine by paramedics—citing perceived agitation—and died days later. The psychiatric justification for sedation was rooted in vague assumptions of "excited delirium" or mental disturbance, neither of which was ever substantiated by medical necessity or legal process.

Christian Glass (2022): Glass called 911 for assistance after becoming stranded. When officers arrived, they perceived his demeanor as "erratic" and labeled him a mental health risk. Despite being unarmed and confined within his vehicle, law enforcement escalated force and ultimately killed him. His mental state became a proxy for imminent threat—resulting in lethal intervention when none was warranted.

Nikolas Cruz and the Parkland Shooting (2018): In Florida, Cruz reportedly pointed a loaded gun at another person prior to the Parkland massacre—an act that could have led to felony charges and a permanent ban on firearm possession. Instead, he was diverted into a civil psychiatric program under a law akin to CRS § 27-65-106. He was released without consequence or adjudication. Weeks later, he

murdered 17 people at Marjory Stoneman Douglas High School. The system's reliance on psychiatric discretion allowed a clear threat to evade accountability, underscoring how civil commitment frameworks often target the harmless while sparing the dangerous.

These cases illustrate a catastrophic pattern: civil mental health holds are applied where they are unneeded—fueling unnecessary state violence—while failing to intervene when public safety truly demands action. The outcome is not enhanced public safety, but the quiet dismantling of confidence in the rule of law.

VII. International Legal Violations

CRS § 27-65-106 not only conflicts with constitutional protections under U.S. law but also fails to meet international human rights standards that govern deprivation of liberty, access to justice, and non-discrimination on the basis of disability. The statute contravenes key provisions of the U.N. Convention on the Rights of Persons with Disabilities (CRPD), the International Covenant on Civil and Political Rights (ICCPR), and comparable global instruments that articulate a unified baseline: psychiatric disability alone cannot justify detention, and no person shall be deprived of liberty without equal procedural protections.

A. United Nations Convention on the Rights of Persons with Disabilities (CRPD)

The CRPD prohibits the detention of persons based solely on disability status. Article 14(1)(b) affirms:

"The existence of a disability shall in no case justify a deprivation of liberty."

CRS § 27-65-106, however, allows for non-consensual psychiatric confinement and forced medication of individuals whose only disqualifying factor is a perceived or diagnosed mental health condition. The statute permits such confinement without requiring evidence of criminal conduct, immediate danger, or judicial findings—all in clear tension with CRPD mandates.

Additionally, Article 13 of the CRPD requires that states guarantee access to justice for persons with disabilities, including necessary accommodations to participate meaningfully in legal processes. While Colorado law provides appointed counsel if detention is extended into certification proceedings, there is no such safeguard during the critical 72-hour emergency hold. During this initial deprivation of liberty, individuals are denied notice, an adversarial hearing, and legal representation—impairing real-time access to legal remedy and violating Article 13's guarantee of procedural equality.

B. International Covenant on Civil and Political Rights (ICCPR)

The ICCPR—ratified by the United States and therefore legally binding—provides in Article 9 that: (1) "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention." (3) "Anyone arrested or detained…shall be brought promptly before a judge." (4) "Anyone who is deprived of his liberty…shall be entitled to take proceedings before a court."

CRS § 27-65-106 fails to meet any of these protections. It authorizes emergency psychiatric holds based solely on non-judicial affidavits, permits confinement without adversarial review, and does not provide any mechanism during the initial 72-hour hold for individuals to challenge their detention in court. While representation may be available in later certification phases, the statute offers no right to counsel, judicial hearing, or notice during the most critical early period of confinement—when liberty is first suspended. Individuals may remain detained for up to 13 days without a single appearance before a judge. Such prolonged, non-adjudicated confinement—grounded in vague assessments of "dangerousness"—constitutes arbitrary detention in direct violation of Article 9. The statute's failure to provide an immediate, meaningful judicial remedy also contravenes Article 9(4). No recognized international legal standard permits the suspension of fundamental liberty interests on psychiatric grounds absent prompt oversight by a neutral court of law.

VIII. Conclusion

The Constitution does not offer conditional protection. It does not yield to diagnostic categories, bureaucratic discretion, or speculative fears. It demands that any deprivation of liberty or bodily autonomy be grounded in evidence, governed by process, and reviewed by a neutral adjudicator. CRS § 27-65-106 satisfies none of these requirements.

This statute permits the seizure of legally competent individuals without probable cause, the administration of forced medication without judicial oversight, and the continuation of confinement after danger has been explicitly ruled out. It abandons the evidentiary standard of Addington, ignores the procedural framework of Mathews, and defies the confinement limits of Foucha. It arms clinicians with unchecked authority while offering no recourse to those subjected to it.

Even the psychiatric profession has disclaimed the statute's core presumption. The American Psychiatric Association, in its Tarasoff amicus brief, acknowledged that predicting dangerousness is "an impossible burden"—a function psychiatrists are "ill-equipped to undertake." And yet this statutory regime not only

demands such predictions but renders them unreviewable.

CRS § 27-65-106 authorizes a regime of confinement, coercion, and compelled medication that bypasses the most fundamental safeguards of American law. It permits government agents—acting without probable cause, without judicial findings, and without adversarial review—to detain individuals not for what they have done, but for who they are perceived to be. That power is exercised not at the margins of due process, but in its deliberate absence.

The statute's reliance on predictive psychiatry as a substitute for judicial process is constitutionally untenable. Under § 27-65-106, forecasts substitute for fact, diagnosis substitutes for proof, and discretion replaces due process. The result is a legal architecture that enshrines arbitrary detention beneath a medical veneer.

The result is not the occasional overreach of a well-intentioned law. It is a system that institutionalizes injustice, invites constitutional violations, and fosters public harm under the guise of care. When patients are taught they have no rights, the foundational idea that everyone has rights begins to erode. And when institutions model lawlessness, they risk producing it in turn.

The Fourteenth Amendment demands more. Colorado law delivers less. This mismatch is not theoretical. It is lived, it is documented, and it is indefensible. CRS § 27-65-106 must be understood for what it is: a statutory framework that enables confinement without cause, treatment without consent, and silence without recourse. Under our Constitution, such a regime cannot stand.

This brief does not seek immediate relief. It preserves a record—for future courts, legislatures, and citizens—to serve as a foundation for deciding whether the regime of psychiatric detention will remain beyond constitutional scrutiny, or whether it will finally be reconciled with the promises of liberty and the rule of law.

Supplemental Affidavit of Material Fact Filed in Support of Judicial Misconduct Complaint and Record Preservation

I. Plaintiff's Account of Judicial Distortion

Plaintiff submits this Affidavit under penalty of perjury to preserve material facts that, in his view, were misrepresented or omitted in the adjudication of Case No. 18-cv-01952. On June 18, 2019, the district court adopted the magistrate judge's recommendation in full, despite conclusions that Plaintiff alleges were directly contradicted by his pleadings and by documentary evidence submitted both to the court and to opposing counsel.

A. Mischaracterization of Federal Claims

The Recommendation incorrectly states that I made "no allegations" of unlawful federal conduct. In fact, my Complaint expressly alleges multiple violations of the Fair Debt Collection Practices Act (F.D.C.P.A.), 15 U.S.C. §§ 1692 et seq., and Colorado Revised Statutes § 18-3-207. Specifically, I alleged that:

Certain debts not authorized by law or agreement were placed on my credit report by the named debt-collector defendants.

Denver Health and Banner Health caused those debt collectors to report the unauthorized amounts on my credit report.

Those allegations plainly qualify both as "collection" under 15 U.S.C. § 1692a(6) and as an "unfair practice" under F.D.C.P.A. § 1692f. As such, the debt-collector defendants performed unlawful collection activity, and the hospital defendants caused them to do so, in clear violation of federal law.

The Recommendation's contrary statement misrepresents the Complaint and risks forfeiture of my F.D.C.P.A. and C.R.S. § 18-3-207 claims. The record must be corrected to preserve these federal causes of action intact.

B. Improper Use of Precedent

The recommendation relied on precedent involving plaintiffs who had been sued and found liable for the

debts at issue. By contrast, Plaintiff was never sued, and no legal proceeding established the validity of the alleged debts. Applying case law predicated on materially distinct facts was therefore improper and legally inapplicable.

C. Omission and Suppression of Submitted Evidence

The Court's conclusion that Plaintiff failed to identify the disputed debts is demonstrably incorrect. The original Complaint set forth detailed factual allegations specifying each debt, including the relevant amounts, the identities of the creditors and collection agencies, and the unlawful method of collection—namely, the placement of debts not expressly authorized by agreement nor permitted by law onto Plaintiff's credit report, in violation of the F.D.C.P.A. and C.R.S. § 18-3-207. These allegations were neither vague nor conclusory. They described precisely how the debts were unlawfully created, reported, and used as instruments of reputational and economic coercion.

In addition to the Complaint, Plaintiff submitted corroborating documentation into the record (see Doc. 37) and separately provided these materials to opposing counsel. Although one counsel may not have received the attachments due to a clerical error, the same documents were later reattached to Plaintiff's motion to vacate judgment. At all relevant times, Plaintiff acted in good faith to ensure the Court and opposing counsel had access to the evidence identifying the disputed debts, the entities involved, and the resulting harm.

Nonetheless, the magistrate judge's recommendation—and the district court's wholesale adoption of it—claimed that Plaintiff failed to provide "identifying information" sufficient to notify Defendants of the debts at issue. That statement is refuted by the record. The Complaint—and supporting exhibits—provided names, amounts, dispute history, and descriptions of how each account was used as leverage. Defendants, all of whom are licensed debt collectors or credit reporting agencies, had every means to recognize the debts in question. The Court not only disregarded these materials—it misstated their existence.

To the extent the Court received and reviewed this evidence—whether in the initial filing, via Doc. 37, or through the motion to vacate—and still permitted the misrepresentation to stand, Plaintiff raises a good-faith concern of fraud on the Court by omission. Officers of the Court, including opposing counsel, had a duty not to allow the Court to be misled by a known factual falsehood. They abandoned that duty. The continued disregard of documented evidence known to all parties compromised the integrity of the proceeding and obstructed fair adjudication of the claims.

II. The Brief and Affidavit as Paired Testimonies

This Affidavit stands in direct relation to Plaintiff's Updated Supplemental Constitutional Record Brief, which preserves unresolved constitutional claims arising from Plaintiff's involuntary detention under CRS § 27-65-105. Where the brief addresses constitutional implications, this Affidavit documents how the judicial process distorted or excluded core factual claims.

Taken together, they form a unified submission:

The brief addresses constitutional questions arising from what occurred.

This Affidavit addresses how the judicial process misrepresented what occurred.

III. Fear of Imminent Harm Under CRS § 27-65-106

This is not legal theory—it is a sworn account of immediate, personal danger that CRS § 27-65-106 creates. I was hospitalized under § 27-65-105 and witnessed how Colorado's civil-commitment apparatus functions not as care but as coercion. I saw people forcibly injected with powerful neurotoxins administered under an "emergency" justification, despite the absence of any actual emergency. Brian was chemically restrained for raising his voice. Catherine, for partial nudity. I myself was ordered forcibly medicated solely for declining prescribed drugs three days in a row. These were not life-saving interventions; they were acts of domination, cloaked in the language of compassion.

One such intervention involved being administered 20 mg of intramuscular Zyprexa in a single dose, despite FDA and manufacturer prescribing guidelines prohibiting doses greater than 10 mg IM without a two-hour interval and reassessment of symptoms. I never gave informed consent. This was not only a breach of medical ethics, but a violation of the official prescribing protocol, which exists precisely to prevent life-threatening adverse events. I submitted a formal complaint to the Colorado Department of Regulatory Agencies (DORA). It was dismissed with no consequence, no recourse, and no explanation. That outcome confirmed what I already suspected: even flagrant violations of clinical safety standards are ignored when performed under the protective banner of involuntary psychiatry. This wasn't an isolated error—it was systemically sanctioned chemical assault.

I fear that CRS § 27-65-106 may one day force me into the same fatal bind that ended Matthew Riehl's life. If I resist an unlawful seizure in self-defense—one undertaken without probable cause, without a warrant, and under a medical pretext that stands in defiance to the Fourth Amendment—I risk being executed on the spot. There is no way to "stay compliant" to avoid that fate, because the statute provides no guidance on how to prevent unwanted seizure, and compliance with the 72-hour hold itself triggers the

very harm I would seek to defend myself against. If I comply, I risk permanent brain damage—or death—at the hands of clinicians empowered to administer neurotoxins without consent, without oversight, and without any legal consequence.

If subjected to a 72-hour hold today, I have no reason to trust I'd receive due-process protections, post-deprivation judicial review, or any neutral forum in which to object in real time. Only unchecked power beneath an unscrutinized veneer of "emergency care"—a regime seemingly designed to evade meaningful review.

This fear is not hypothetical. Once an involuntary hold begins, procedural safeguards evaporate. Courts do not intervene in time—if they intervene at all. I know this because I have lived it. I do not believe the system would protect me.

Although Clear View Behavioral Health—the facility where I was held with Brian and Catherine—has since closed, its closure offers no assurance of future safety. Due process is not a physical structure. It is a structure of law. And where that structure is absent, it does not matter what name is on the sign outside the building. The core constitutional defect remains: there is no meaningful oversight, no enforceable standard, and no reliable way to assess how a facility will operate until it's too late. Even if robust procedural protections were universally adopted tomorrow, they would not resolve this fear—because the only way to know whether those protections are honored is to be inside the system, at which point the decision to comply or resist in self-defense has already been forced.

There is no safe, lawful route through this statute for a law-abiding citizen—only the hope that this record may someday help a future court strike down CRS § 27-65-106 as unconstitutional. My safety depends on that outcome. And that outcome lies beyond my control.

The enforcement of this statute against me would impose upon me a binary decision no law-abiding person should ever have to face, especially at the hands of law enforcement officers: submit to the chemical destruction of my brain—or die. Matthew Riehl's death was not an outlier; it was the foreseeable result of a legal regime that treats the mentally ill not as citizens but as undesirables—unworthy of rights.

If CRS § 27-65-106 remains in force, the next tragedy is not a matter of if—but of who. And whether, next time, that name will be mine.

IV. Forcible Drugging of a Calm, "Gravely Disabled" Patient; Overdose, Forged Consent, Police Refusal to Investigate

On August 1, 2013, my medical records indicate that I was calm when they injected me with Zyprexa

against my will after being held for paranoid thoughts and abnormal speech. One hospital note explicitly states, “The patient has been calm and stabilized with Zyprexa here.” Another note reads: “The patient will not communicate with me. He has been uncooperative. States he wants a pen and paper to write things down so he has does have records so he can sue for being kidnapped…” That quote sounds like me—except for the grammar error, which does not.

This forced injection, without documented emergency or court order, may have violated both Colorado law governing non-emergency involuntary medication as it was implemented in 2013, and my federal constitutional right to bodily autonomy under the 14th Amendment, as recognized in Washington v. Harper, 494 U.S. 210 (1990).

Although Washington v. Harper, 494 U.S. 210 (1990), permits emergency involuntary medication without a prior hearing, it requires a meaningful post-deprivation review to assess whether the emergency was legitimate and the intervention justified. In my case, despite being forcibly medicated multiple times while not dangerous, no such review ever occurred. I was never offered a hearing, never informed of a right to contest the treatment afterward, and never afforded any neutral forum to assess whether the statutory criteria for emergency intervention were truly met. This denial of post-event process—repeated across years and institutions—stands in direct violation of the minimal procedural safeguards contemplated by Harper and renders the emergency exception a de facto exemption from all accountability.

Additionally, on September 16, 2015, during my involuntary hold at Banner Health, Dr. Curtis Henderson ordered a single 20 mg intramuscular dose of Zyprexa, which was then forced on me without my consent. This is double the 10 mg maximum permitted without a two-hour reassessment under the manufacturer’s safety label. Zyprexa in IM form produces blood plasma levels five times higher than the same dose in pill form, increasing the risk of adverse events.

That same day, Banner staff falsely recorded “verbal from PT” on my treatment forms, forging consent when none was given. Fabricating a patient’s consent to medical treatment, especially to a chemical restraint overdose, may constitute a felony-level violation of C.R.S. § 18-5-102(1)(c), which prohibits knowingly making false entries on written instruments calculated to be relied upon as contracts.

After obtaining my medical records in preparation for this lawsuit and discovering the forgery, I filed Fort Collins Police Dept. Report No. P180570214 with Officer Brian Werder to document both the chemical battery and the forged consent entry. Officer Werder accepted the report but declined to open any investigation, closing it with no further action. A transcript of the moment I discovered the forgery while I was at the hospital to get my medical records was included in the motion to vacate final judgment.

This multilayered suppression of truth—including forcible medication without a documented emergency, administration of a dose twice the permitted maximum, falsified medical records, and law enforcement’s

refusal to investigate conduct plausibly in violation of multiple statutes—deepens my good-faith concern that involuntary hospitalization is dangerous and that its due-process protections are illusory.

V. Conclusion

Plaintiff affirms that this Affidavit is submitted in good faith, under penalty of perjury, for the purpose of preserving the factual record and enabling accurate review under the Judicial Conduct and Disability Act.

He does not write for effect. He writes for the file. He asks only that what was pleaded, what was submitted, and what was misrepresented be acknowledged—and preserved.

Verification

I, Andrew W. Jurgensen, declare under penalty of perjury under the laws of the United States of America that to the best of my knowledge, the foregoing is true and correct.

Executed on 09JUL2025.

Andrew W. Jurgensen Plaintiff, Pro Se